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ABSTRACT

Five hundred and twenty six journal articles, monographs, books and reports dating from 1970 to 1974 comprise this bibliography on issues relating to and attempted solutions of the health problems of minority urban youth. Documents are classified under the following headings: health problems and behavior of ethnic and racial minority groups, health problems related to growth and development, health and environment, learning disabilities, school and community health delivery systems, services and policies, school and community health care personnel, educating health consumers, physical fitness, and recreation and health. The following observations are made: (1) societal health problems can often be identified early in a person's life; (2) school is a critical factor and force in prevention of and treatment of health problems; (3) school personnel are not adequately trained to deal with health problems, and health workers in the community are not aware of health problems and programs in the schools; and, (4) ethnic minority children are most vulnerable to health problems and least likely to receive remediable services. (Author/AM)

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Number 45, August 1975

Health and the Urban Poor

A Bibliography

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INTRODUCTION

This bibliography was compiled to provide the reader with a reference on the health status, needs, and problems of various ethnic and minority groups in the preschool and school-age population. It cites works which state the issues and those which discuss some of the attempted solutions. The literature is vast and covers several disciplines. Such an ambitious undertaking is never complete. The materials finally selected for inclusion are journal articles, monographs, books, and report literature produced between 1970 and 1974 in the United States. They are classified here under the following headings: 1) Health Problems and Behavior of Ethnic and Racial Minority Groups; 2) Health Problems Related to Growth and Development; 3) Learning Disabilities; 4) Health and Environment; 5) School and Community Health Delivery Systems, Services and Policies; 6) School and Community Health Care Personnel; 7) Educating Health Consumers; and 8) Physical Fitness, Recreation and Health. While every attempt was made to list each article under the most appropriate heading, several articles could have been classified under more than one area. In these cases, the article was put in the most descriptive or the broadest category.

It should be noted that while the focus was on urban minority youth, the bibliography does cite materials which deal with the special problems and programs for children of migrant and seasonal workers. To an even greater degree than with urban populations, the school has become the vehicle for health care for these groups because it is the one institution which initiates and maintains contact with these children. These citations may be looked at for implicit information on the further use of the school as a health care vehicle as well as for explicit information on the particular population covered.

In an attempt to guide the user of this bibliography, a brief review of the material included in each section is presented below. The articles commented upon represent the breadth and depth of each specific category.

I.

Listed under "Health Problems and Behaviors of Ethnic and Racial Minority Groups" are 83 articles concerned with the identification of health problems and proposals, programs and services designed to alleviate these problems. Among the ethnic and minority groups discussed are blacks, American Indians, Hawaiians. Chinese Americans, Mexican Americans, Puerto Ricans and other Spanish-speaking groups. These groups face a broad spectrum of health problems. including those that are genetically induced (i.e., sickle cell anemia),

environmentally influenced (i.e., drugs, alcoholism, suicide and cancer) and both economically and educationally determined (i.e., nutritional and dental problems). One must of course remember that the specific problems often have a variety of causes.

In addressing the issue of health problems, it is first necessary to formulate a reference point as to what is meant by health. This context is provided by two articles. The first of these by Salk (#66) offers a definition of health. In his view, it is "a state in which the potential of the individual is developing in a balanced way, that he may cope with the vicissitudes of life and function fully in the service of life in evolution." While this article is philosophical, it does present a starting point to be used in describing an elusive state for which most human beings strive. Murphy (#48) presents another context from which health can be considered. He views health problems in terms of values. The eight areas he uses to discuss health are: affection, enlightenment, skill, power, respect, rectitude, physical health and well-being.

Using these contexts we can now turn our attention to health problems and the role of the school. It has long been accepted that the school is the institution designated by society to educate and mold the young. For approximately six hours a day, children are a captive audience in an environment that shapes their future. In more recent times, this institution is being called upon to assume the role of health care provider, in addition to the role of health educator. For example, Paige (#56), in "Health Problems for the Disadvantaged: Implications for School Health," proposes a new type of health delivery system as the goal of the school health program. In an article by Dougherty (#17), "A School Health Program for the Children of Migrant and Seasonal Agricultural Workers," the services and programs provided to the children are identified and discussed. These include physical examinations, immunizations, dental health care, nutritional care, child study teams, a school transfer record system, correction of physical defects and eye health care.

These kinds of programs are not yet the rule, however. The need for school-based health care is exemplified by the findings of a study conducted by Eisner, Cobb, and Tortosa (#20), "The Effectiveness of Health Screening in a School Program for Migrant Children." They describe how a demonstration program utilizing screening teams outside of the normal channels of health care resulted in the discovery of many health defects, but in the treatment of less than half of them. The authors conclude that "children who go without needed medical treatment generally do so because of a failure of follow-up rather than a failure of case-finding." Hence, the availability of school-based health care could bridge the gap between detection and correction.

The health problems of any group can be emotional and psychological as well as physical. The articles by Jones (#29), "A Public Health Approach to Emotional Handicap in the Schools," Mullen (#46), "Psychological Services to Spanish Speaking Children in the Schools of Chicago," and Rueveni (#65), "Using Sensitivity Training with Junior High School Students," describe how the school and the community must work together as a unit in providing psychological services to the young.

Consideration is given to factors which influence health such as cultural beliefs, habits and life styles, in the articles by Li, et al. (#39), "Health Care for the Chinese Community in Boston," McRae and Nelson (#42), "Youth to Youth Communication on Smoking and Health," and Sanjur, et al. (#69), "Milk Consumption Patterns of Puerto Rican Preschool Children in Rural New York." Each author identifies and discusses how these forces operate in the day-to-day life of the specific group being assisted.

In summary it can be seen that the parameters involved in defining and solving the health problems of ethnic and racial groups as related to their behavior are broad and extensive. The settings, populations and issues are many and complex. Any solutions must be just as varied and complex.

II.

The category, "Health Problems Related to Growth and Development," lists 75 publications with a focus on the various conditions that can develop or occur during the early part of the life cycle which may affect health. Among these are accidents, poisonings and suicides, the largest causes of death for the 15- to 19-year-old age group. Not equally as deadly, but of similar importance and seriousness are the problems of diabetes, cystic fibrosis, peptic ulcer, pregnancy and tuberculosis. For some of these handicaps, the patients will require counseling in order to adjust to a life of limited physcial activity. For others, life-long treatment and medication will be required.

All of these articles stress either implicitly or explicitly the need for early identification and correction of these specific physical problems. In the articles by Densen, et al. (#92), "Childhood Characteristics as Indicators of Adult Health States," and Brophy (#87), "Project Pursuit--A Health Defect Follow-Up Activity," specific data are presented on how important it is for the schools to conduct early case finding. Many remediable situations go untreated among the young, and often become irreversible conditions in later life, limiting both life expectancy and individual opportunity.

Increased levels of stress in children can both limit attention span and restrict human interaction. Leighton (#118) in his article on "Measuring Stress Levels in School Children as a Program-Monitoring Device " presents a simple, quick and apparently effective technique for detection.

In general, then, the selections in this section provide the reader with an overview of both the common and some of the uncommon health needs found among preschool through high school age children.

III.

The category on "Learning Disabilities" includes articles on the health problems of school children that can, and often do interfere with learning. While no rigid definition of "learning disability" was followed in classifying the readings for this section, selection was influenced by those articles indicating attempts at correlating school success or failure with the existence of a health (physical, emotional or psychological) problem. The type of disability chosen for inclusion here is best illustrated by the definition of learning disability used by Uyeda (#236), "any condition which hampers a child from understanding, assimilating, and using the materials which are presented to him at school and at home."

The problem of defining and classifying conditions as learning disabilities is illustrated in the article by Lerner (#212), "Learning Disabilities: A School Health Problem," in which she presents several classes of disabilities. Her listing includes: 1) neurological dysfunction or brain impairment; 2) uneven growth pattern; 3) difficulty in academic and learning tasks; 4) discrepancy between achievement and potential; 5) definition by exclusion; and 6) the U.S. Congress' official definition of learning disability.

Every school and health worker needs to be alerted to his role as case finder of children with existing or potential learning disabilities. The articles by Freeman (#191), "Learning Disabilities and the School Health Worker," Griffen (#195), "Learning Disabilities: Implications for Medicine and Education," Callan and McCray (#172), "Case Studies on Remediable Health Defects," and Chinn (#174), "A Relationship between Health and School Problems: A Nursing Assessment," address themselves to the role various professional groups can perform. Early symptoms of defects that may be evident to the observer are discussed in detail. Included are: confusion, need for constant attention, destructiveness, lack of directionality, distractibility, hyperkinesis, moodiness and emotional instability, short attention span, lack of coordination and other visual or auditory perceptual characteristics.

The relationship between malnutrition and mental development is addressed by both Gussow (#198), "Nutrition and Mental Development," and Hertzig, et al. (#202), "Intellectual Levels of School Children Severely Malnourished During the First Two Years of Life," each from a different point of view. Gussow concludes that "malnutrition produces what might be called mental retardation only when it occurs in early infancy and is both severe and prolonged." Even under such circumstances, rehabilitation appears to be possible if the children in question are provided with both adequate food and appropriate intellectual stimulation. Hertzig, on the other hand, indicates that "children who have experienced severe malnutrition in the first two years of life have lower levels of intelligence at school age than their siblings and classmates." However, she goes on to show that there is "no association between the intellectual level of cases and the ages at which the children were hospitalized for the treatment of severe malnutrition during the first two years of life." While no

definitive conclusions can be drawn from the studies of either one of these two researchers, the studies do serve to highlight the continuous difficulties faced by investigators. No simple answer can be given to this very complex and multifaceted problem.

IV.

An extensive, comprehensive listing of 139 readings is included under the heading, "School and Community Health Delivery Systems, Services and Policies." These articles describe not only details of programs, but also the governing policies and legislated acts they rest on. Articles dealing with all previously described health problems and needs in relationship to the school and community health programs are included in this section. Additional information on how school and community systems are working together to respond to the pressing needs of children is also presented.

The articles by Campbell, Garside, and Frey (#251), "Community Needs and How They Relate to School Health Program: S.H.A.R.P.--The Needed Ingredient;" Eisner (#265), "Health Services under the Elementary and Secondary Education Act;" Nyquist (#331), "Imperative--Redesign for Health Education with Particular Reference to the Program in the State of New York;" and the American Academy of Pediatrics Committee on School Health (#243), "Statement on Health Education," all point out the inseparability of health services and health education. Often they are viewed as two separate and distinct resources, yet the outcome of one is very much influenced by the input of the other.

To illustrate, Campbell, Garside and Frey describe how health defects found by school health examinations are often uncorrected despite availability of diagnostic and treatment facilities. Eisner states that few educators are familiar with the details of planning effective health services, nor do they generally know what outside resources in a community should be coordinated with school programs. Nyquist, on the other hand, sees the teacher as a stimulator of discussion and the student as a participant in planning programs, assisting in the classroom and identifying resources in the community.

The American Academy of Pediatrics Committee on School Health views health education as follows:

1) Health education should be a part of every elementary and secondary school teacher's training program;
2) Professional preparation programs in health education must be developed in the schools of education, which should set high standards with requirements as exacting as those in any other area of instruction;
3) The total health education program in the elementary and secondary schools should be directed by trained health educators functioning in consultation and cooperation with

the school's medical personnel and the community's physicians and health agencies. The director should also be certified as a teacher in health education and educated by studies in biological, social and behavioral sciences;

4) A unified, comprehensive and highly developed program of health instruction for the teaching of healthful living should be given from K-12. State governments should legislate this health instruction.
5) The emphasis of the entire program should be on the utilization of facts, principles, and concepts pertaining to healthful living and the making of wise decisions for solving personal, family and community health problems.
6) Health education programs are of such importance and pertain to such large numbers of activities in a society that their financial support must be assured.

The theme of school and community health care is further demonstrated in the articles by Cowen (#257), "Denver's Preventive Health Program for School-Age Children," McFadden and O'Brien (#308), "Increasing the Effectiveness of School-Community Health Programs--A Nursing Viewpoint," and Wethers and Cousens (#376), "Child Health in a Harlem Elementary School." These articles describe programs that were designed to increase the effectiveness of the existing health personnel and delivery systems as they dealt with the problems of school children.

Two articles on health programs that are not successful and that may even be harmful have been included in this bibliography. In one report, Paige (#332), "The School Feeding Program: An Underachiever," the findings indicate that school lunch programs do not appear to be improving the nutritional status of school children. In another, Paige, Bayless, and Graham (#334), "Milk Programs: Helpful or Harmful to Negro Children?" a paradox within public health nutrition programs is presented. The question which is asked is: are we attempting to upgrade the nutritional status of disadvantaged Negroes with food products that a large number of individuals cannot physiologically tolerate?

Increasingly, there is a move towards the use of behavior modification techniques for dealing with particular problems that have not been solved by other methods. Three articles, those by Corbett and Roberts (#255), "Reclaiming the Infuriated in a Ghetto-Area School," Kappelman, et al. (#296), "A Unique School Health Program in a School for Pregnant Teenagers," and Snow and Brooks (#361), "Behavior Modification Techniques in the School Setting," describe general behavior modification procedures involved, how they can be implemented, and how effective they are in a school setting.

V.

The delivery of health services and education requires a corps of health workers who at best function as a team, and at worst as solo independent practitioners. The 113 articles in the section on "School and Community Health Care Personnel" describe the various performances required of these professionals in an educational setting. The most diverse role is that of the nurse, who might assume a variety of titles: nurse counselor, campus nurse, community health nurse, nurse-teacher, school nurse practitioner and school nurse. Other related practitioners who are discussed in this section are: pediatricians, physicians, health educators, psychologists, human relations specialists, sex educators, hearing and speech clinicians, occupational therapists, Red Cross volunteers and nonprofessional human service personnel.

The school has provided a setting and a need for the development of different programs to train health professionals for non-traditional roles. The articles by Doster (#411), "What Can Personnel Contribute to Education?" Lampe (#443), "Preparing School Health Personnel," Beal (#384), "The School Nurse Role--A Changing Concept: Use of System Analysis in Program Planning," contain illustrative discussion of some of the changes which need to be made in training programs for health professionals and the issues involved in updating long-established positions.

Being held accountable for results is another demand that health workers, as well as educators, are learning to adapt to. Dickerson in his article (#410) on "School Nursing Becomes Accountable in Education Through Behavioral Objectives" and Ferinden (#414) in his article on "The Role of the School Nurse in the Early Identification of Potential Learning Disabilities," identify, analyze and discuss the advantages and disadvantages of this movement. Finally, Kuhli (#441), "Education for Health Careers," presents a statement on the potential force of school health programs and personnel as "a major factor in improving the health care system in this country."

VI.

"Educating Health Consumers" contains 25 articles which address themselves to the concerns of educating future consumers in terms of personal health, the use of health services and products, and the prevention of health problems. The various readings emphasize that the education of the public should be initiated in kindergarten and continued throughout the school years. The questions of what to teach, when to teach, how to teach, and why teach children about health are considered in some depth. The article by Douse (#502), "Health Hints or Health Philosophy," raises the issue of how instruction in health education must be combined with development of analytical and critical powers in order that future health consumers be able to function as intelligent decision-makers. Some of the difficulties encountered by health educators in

carrying out their roles are identified and discussed by Callan (#498), "The Growing Influence of Health Problems on School Health Education," Aubrey (#495) "Health Education: Neglected Child of the Schools," and Benningsohn, Stanley and Kolucki (#496), "A Health Education Resource Center for Kindergarten." Innovative techniques and approaches in health instruction are considered in the articles by Allen and Holydak (#493), "Evaluation of the Conceptual Approach to Teaching Health Education: A Second Look," and Edwards, Penick and Suway (#503), "Evaluating the Use of Television in Community Mental Health Education." In summary, the readings in this section indicate a shift in health education away from being a straight information-giving program to a course on informed decision-making, values clarification and behavior modification.

VII.

Two other sections of the bibliography contain a total of 17 items. Eight articles, included under the heading of "Health and Environment," deal primarily with air and water pollution and safety. "Physical Fitness, Recreation and Health" includes nine articles which have implications for health, education, services, and research.

Summary

The above review suggests several observations:

1) The health problems of a society can often be identified early in the life of its members; adulthood is too late for correcting deficiencies and defects that could be prevented, arrested or reversed in childhood.

2) The school is the social institution through which most members of society will pass and is therefore a critical factor and force in the prevention and treatment of health problems.

3) School personnel are not adequately trained to identify or manage health problems, and often are not knowledgeable of available community resources. Health workers in the community are not aware of health problems and programs in the schools.

4) Ethnic/minority children in the schools are the segment of the population most vulnerable to health problems, but least recipient of remediable services.

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APPENDIX

In the fall of 1974, the American Public Health Association held its 102nd Annual Meeting. It had as its theme, "The Health of Minorities and the Poor." In order to highlight the concerns and document the needs of these various groups, a Minority Health Chart Book was prepared and distributed to the program participants. Data selected from this resource is presented here in order to provide an overview of the differences and differentials between these minorities and the white anglo population. Although the Chart Book omitted any interpretative or critical analysis, commentary on the eight selected charts is included here in order to provide some background for the information presented in the bibliography.

It has long been noted that women outlive men and whites outlive non-whites. However, Chart 1 does indicate the beginning of a shift in death rates; non-white females are outliving white males.

Charts 2 and 3 document the high death rate of black Americans and American Indians during the period from birth to one year. In reviewing the extensive amount of mortality data presented in Chart 4, several questions become evident concerning the differences in causes of death when comparing one ethnic/racial group with another. For example, why are accidents, poisonings and violence, the second highest cause of death for American Indians, but only third for all other groups? Why are diseases of the digestive system the third highest cause of death for this same minority group, only sixth for black Americans, but fifth for all the other groups? Why are black Americans disproportionately dying in larger numbers due to perinatal anomalies than any of the other groups? Why do Chinese Americans die at a higher rate from infective parasitic diseases than white and other American groups? Why do Japanese Americans die at a higher rate from diseases of the genitourinary system than other members in the population?

Charts 5 and 6 raise two similar questions: Why is hypertensive heart disease two-and-a-half times greater among blacks than among whites? Why is the prevalence of nutritional deficiencies (including low hemoglobin levels) higher among blacks than among any of the other ethnic/racial groups?

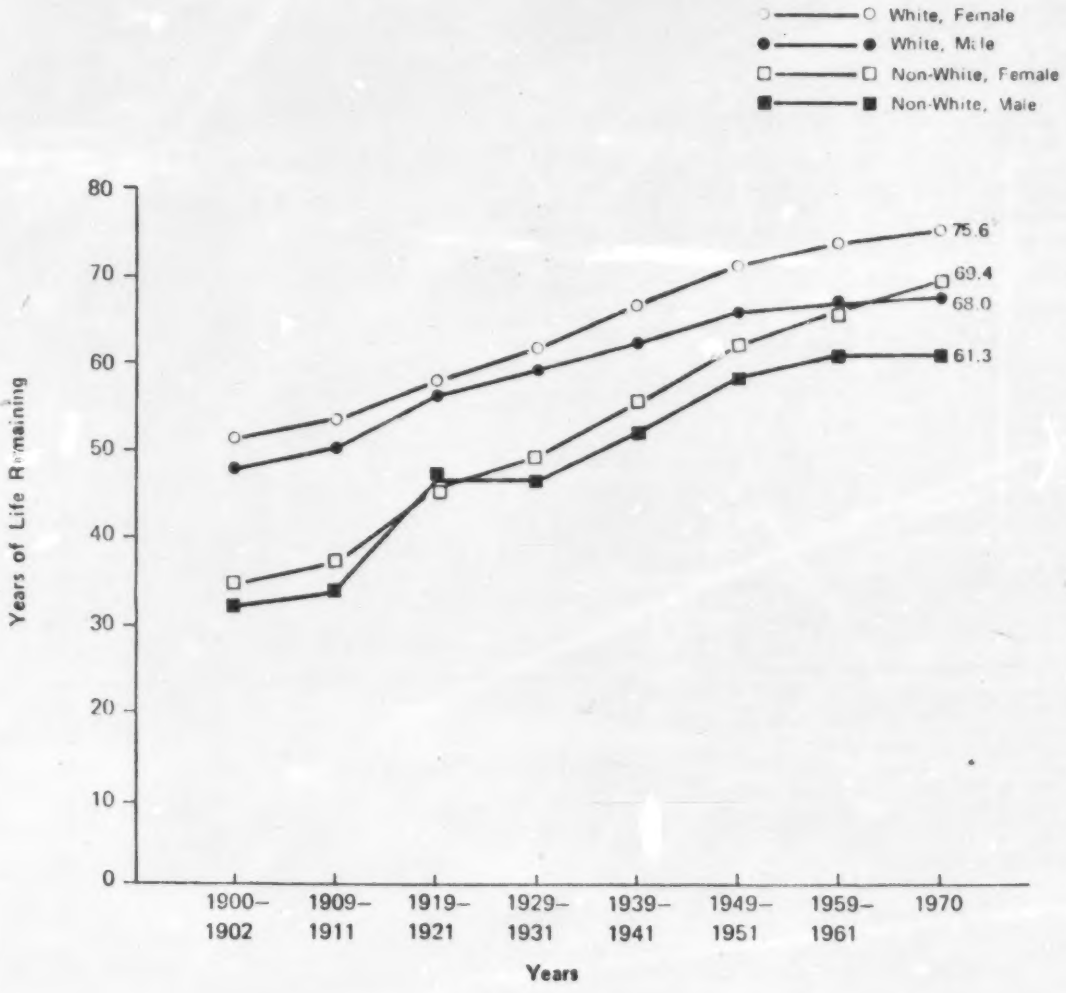
In considering income status and household density, Charts 7 and 8 respectively, indicate that both native and black Americans have the highest percent of households with more than one person per room.

In summary, these charts do serve to highlight a grim picture of health for several of the minority groups. Overall, these groups, especially blacks,

native Americans, and Spanish origin Americans, die in greater numbers, at an earlier age, suffer from more hypertension and nutritional deficiences, are poorer and live in more crowded conditions than any other group in the United States.

CHART 1

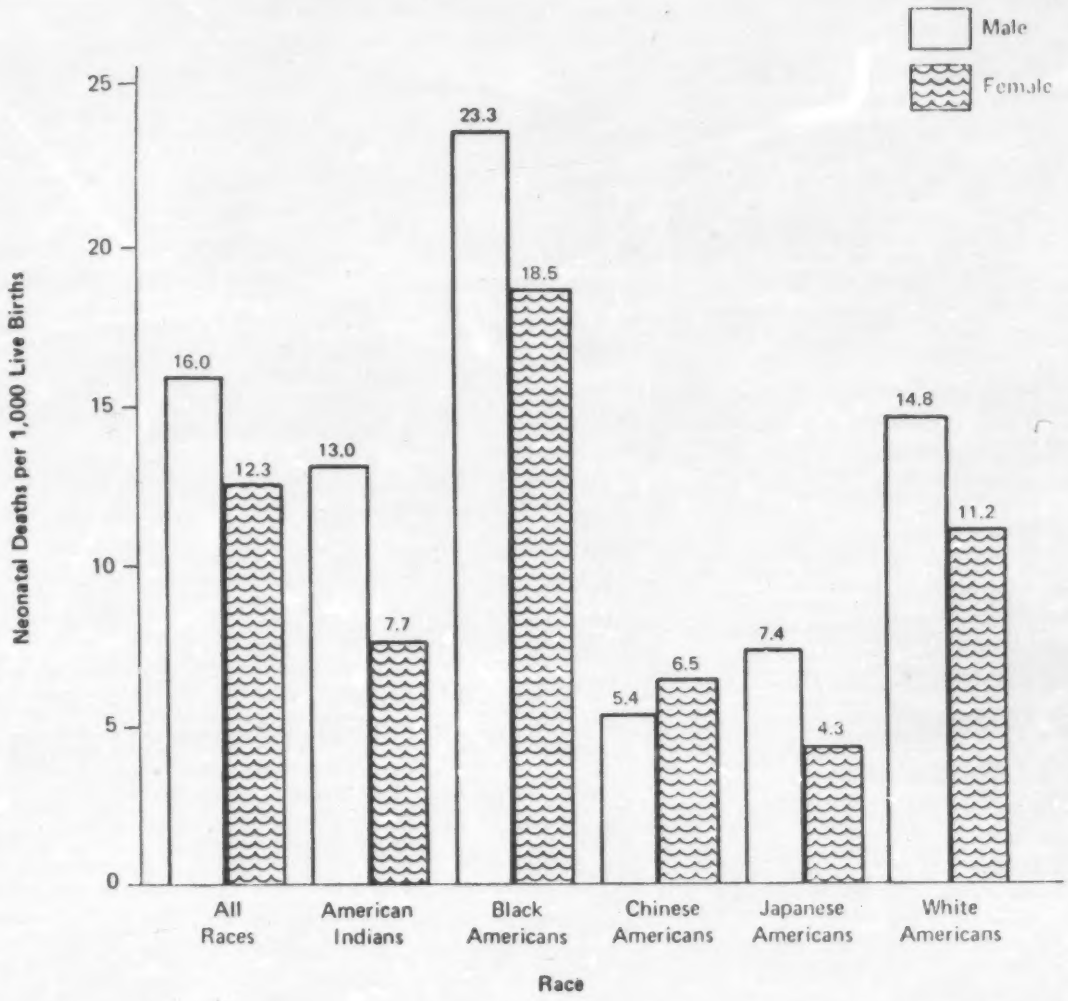
YEARS OF LIFE EXPECTANCY AT BIRTH
BY RACE AND SEX, U.S. 1900–1970



Life Tables, Vital Statistics of the United States 1970 Vol II, – Section 5, U.S. Dept. of Health Education, and Welfare; Rockville, Md., p. 5–13

CHART 2

NEONATAL MORTALITY* RATES BY RACE, U.S. 1971

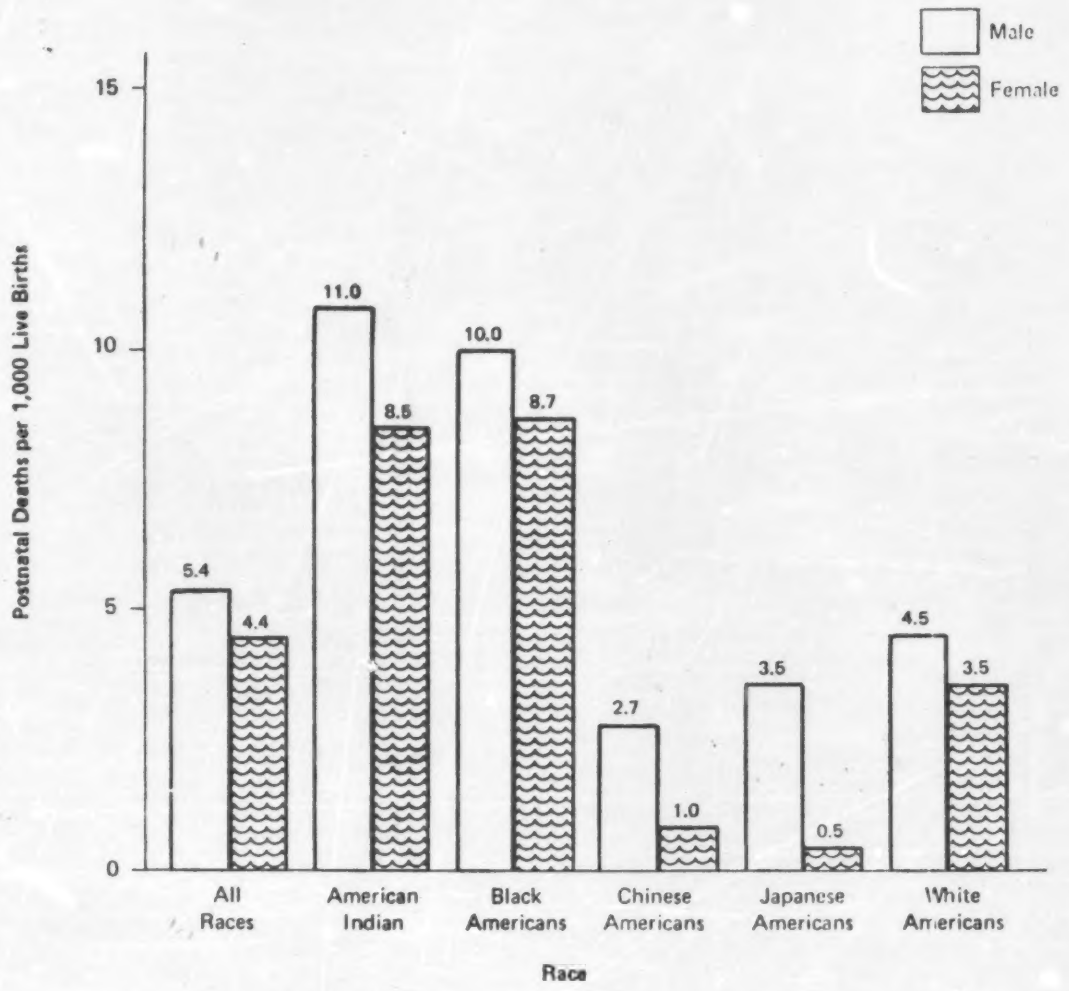


*Deaths between birth and 28 days

Unpublished data from the Division of Vital Statistics, National Center for Health Statistics, Dept. of Health, Education, and Welfare, Rockville, Md., March 1974.

CHART 3

POSTNATAL MORTALITY* RATES BY RACE, U.S., 1971



*Deaths between 28 days and 1 year

Unpublished data from the Division of Vital Statistics, National Center for Health Statistics; Dept. of Health, Education and Welfare; Rockville, Md., March, 1974.

CHART 4

*MORTALITY RANKINGS FOR ALL DISEASE CATEGORIES BY ETHNIC/RACIAL GROUPS, U.S. 1971

	Disease Categories	All Races		Ethnic/Racial Groups Mortality Rankings				
		Deaths Per 100,000	Mortality Rank	American Indian	Black Americans	Chinese Americans	Japanese Americans	White Americans
I	Infect ve Parasitic Diseases	7.9	10	9	10	7	9	12
II	Neoplasms	168.5	2	4	2	2	2	2
III	Endocrine, Nutritional, and Metabolic Diseases	22.7	6	7	8	6	6	6
IV	Blood Diseases	2.6	14	15	14	13	14	14
V	Mental Disorders	4.1	13	10	11	15	15	13
VI	Nervous System Diseases	7.8	11	13	12	12	11	10
VII	Circulatory System	508.7	1	1	1	1	1	1
VIII	Respiratory System	53.2	4	5	4	4	4	4
IX	Digestive System	36.5	5	3	6	5	5	5
X	Genitcurinary System	13.5	8	11	9	8	7	8
XI	Complications of Pregnancy and Childbirth	0.3	17	17	17	17	17	17
XII	Skin Diseases	0.9	16	16	16	16	16	16
XIII	Muscular Diseases	2.4	15	14	15	14	12	15
XIV	Congenital Anomalies	7.8	12	12	13	10	10	11
XV	Perinatal Anomalies	18.9	7	8	5	9	8	7
XVI	All Defined Conditions	13.0	9	6	7	11	13	9
XVII	Accidents, Poisonings, and Violence	79.4	3	2	3	3	3	3

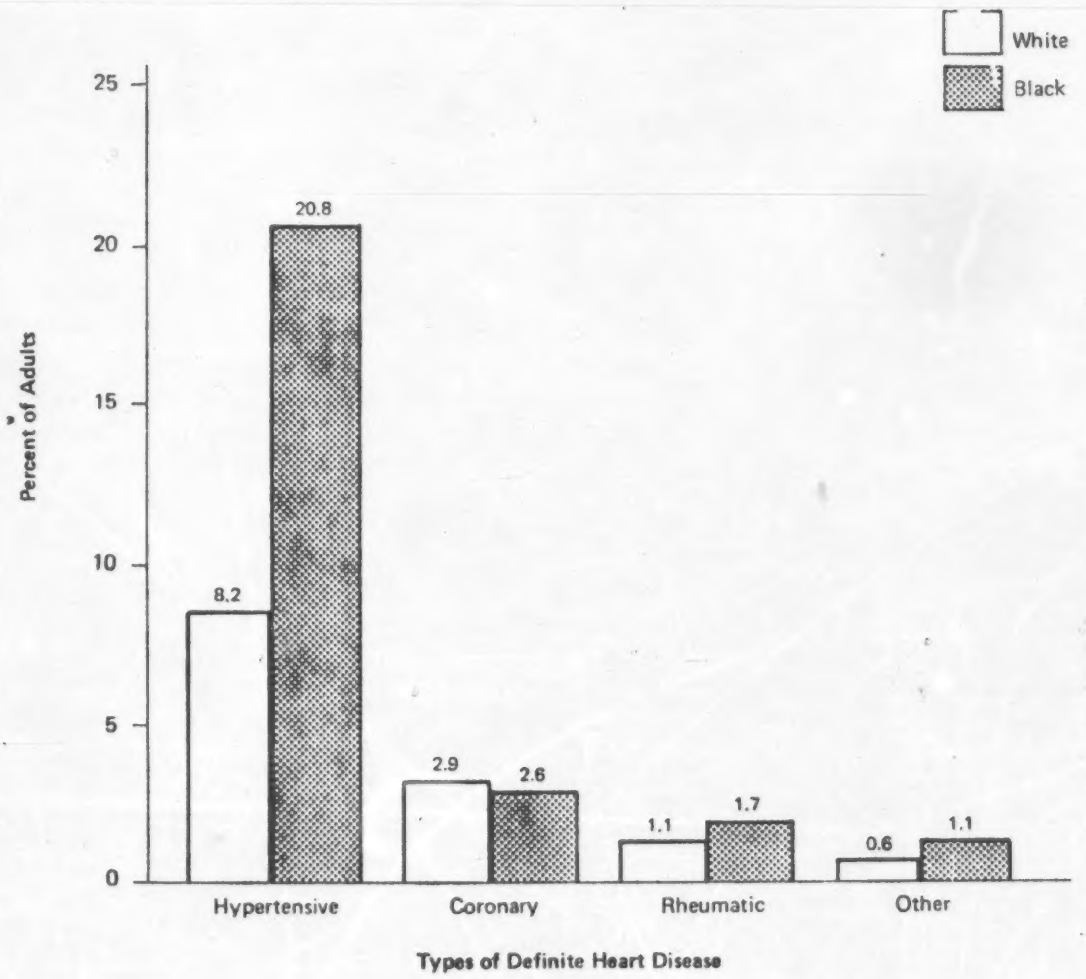
*Rankings are ordered with the disease categories having the highest mortality rate represented by the lowest number.

Source:

Unpublished Data, National Center for Health Statistics; U.S. Health, Education, and Welfare; Rockville, Md.

CHART 5

PREVALENCE OF DEFINITE HEART DISEASE IN ADULTS BY DIAGNOSIS, BY RACE, U.S., 1960–62

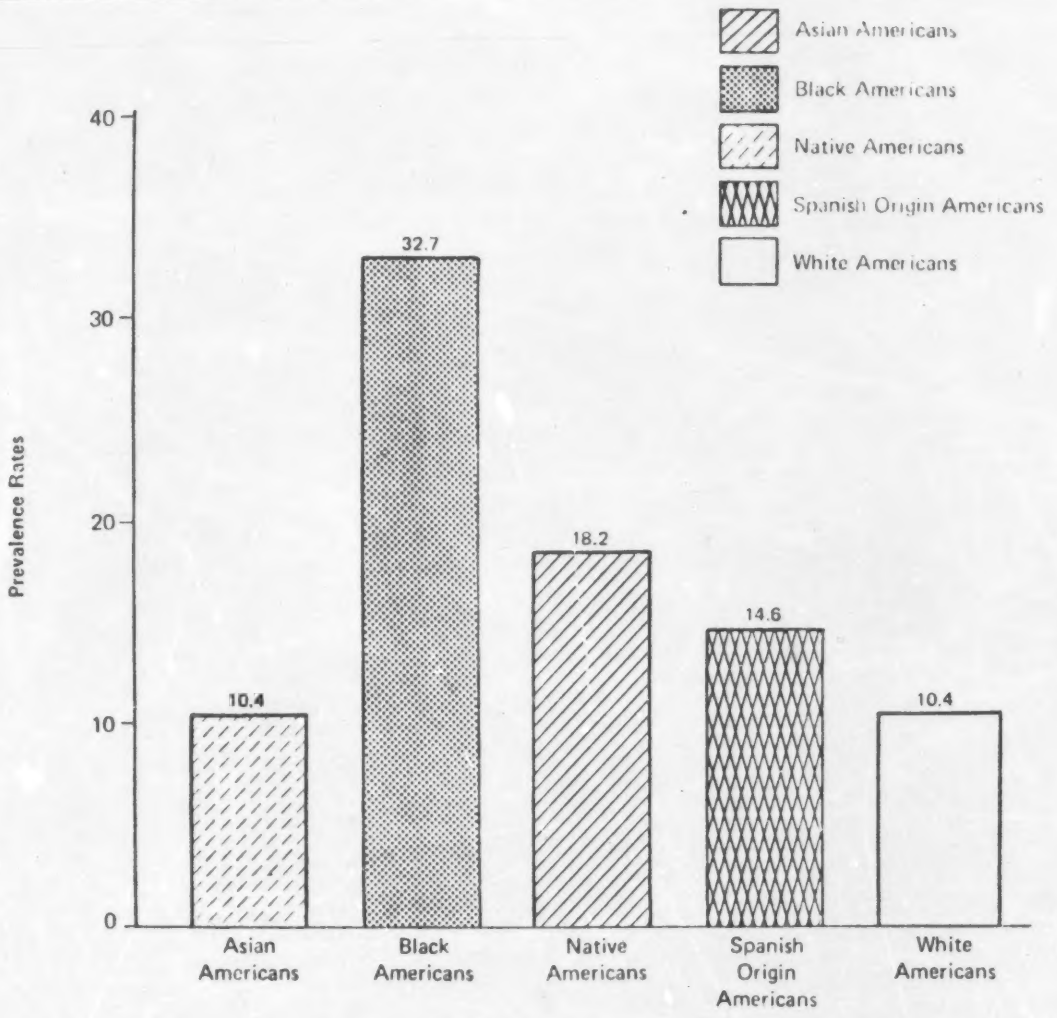


"Heart Disease in Adults, U.S. 1960–1962," Vital and Health Statistics, Series 11:6, National Center for Health Statistics, U.S. Dept. of Health, Education and Welfare, Table: C, p. 9.

A7

CHART 6

PREVALENCE OF NUTRITIONAL DEFICIENCIES
(INCLUDING LOW HEMOGLOBIN LEVELS)
TEN STATE NUTRITION SURVEY, U.S. 1968



Unpublished data from Office of Planning and Evaluation, National Institutes of Health, U.S. Dept. of Health, Education and Welfare

CHART 7

PERCENT OF FAMILIES BELOW POVERTY LEVEL BY ETHNIC/RACIAL GROUP, U.S. 1969

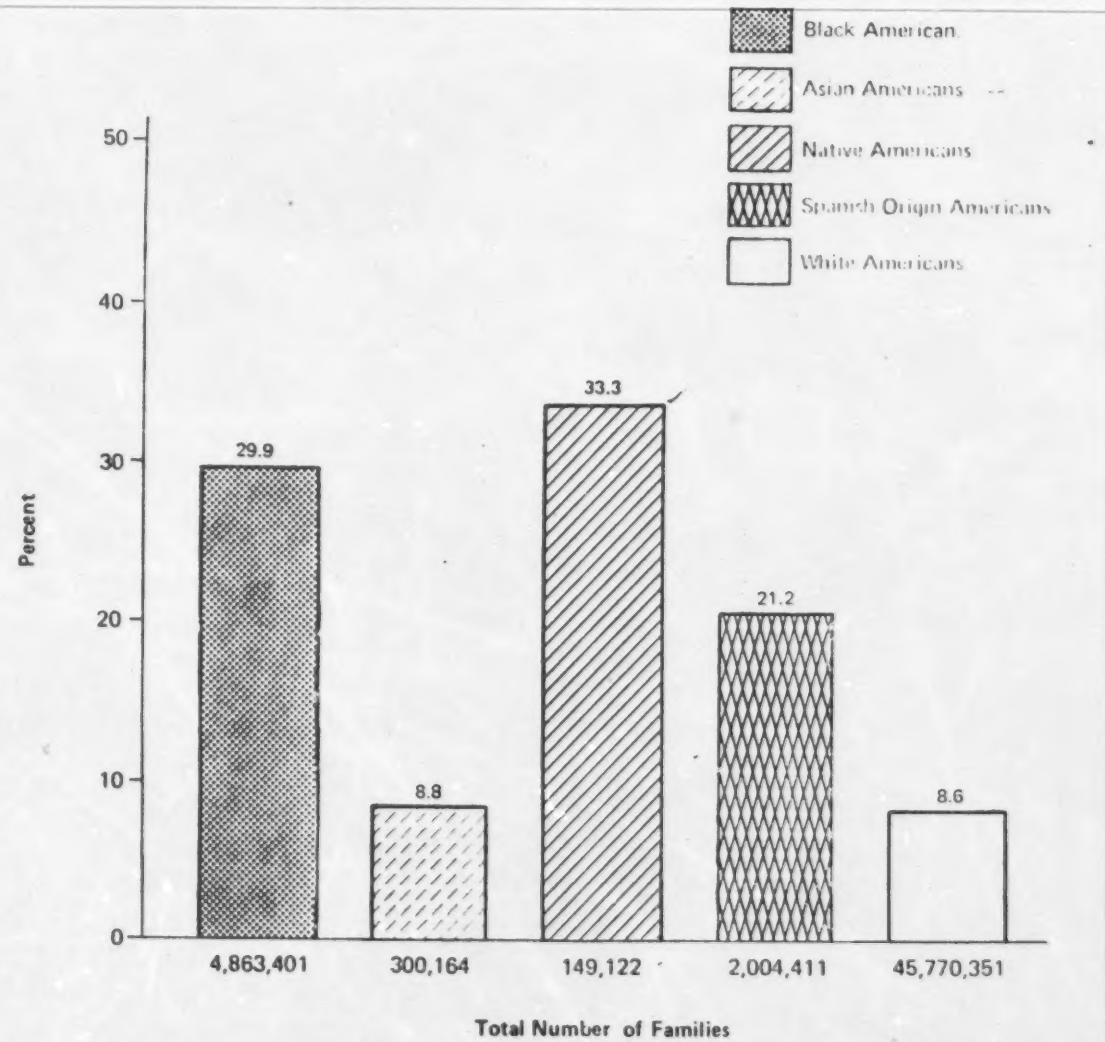


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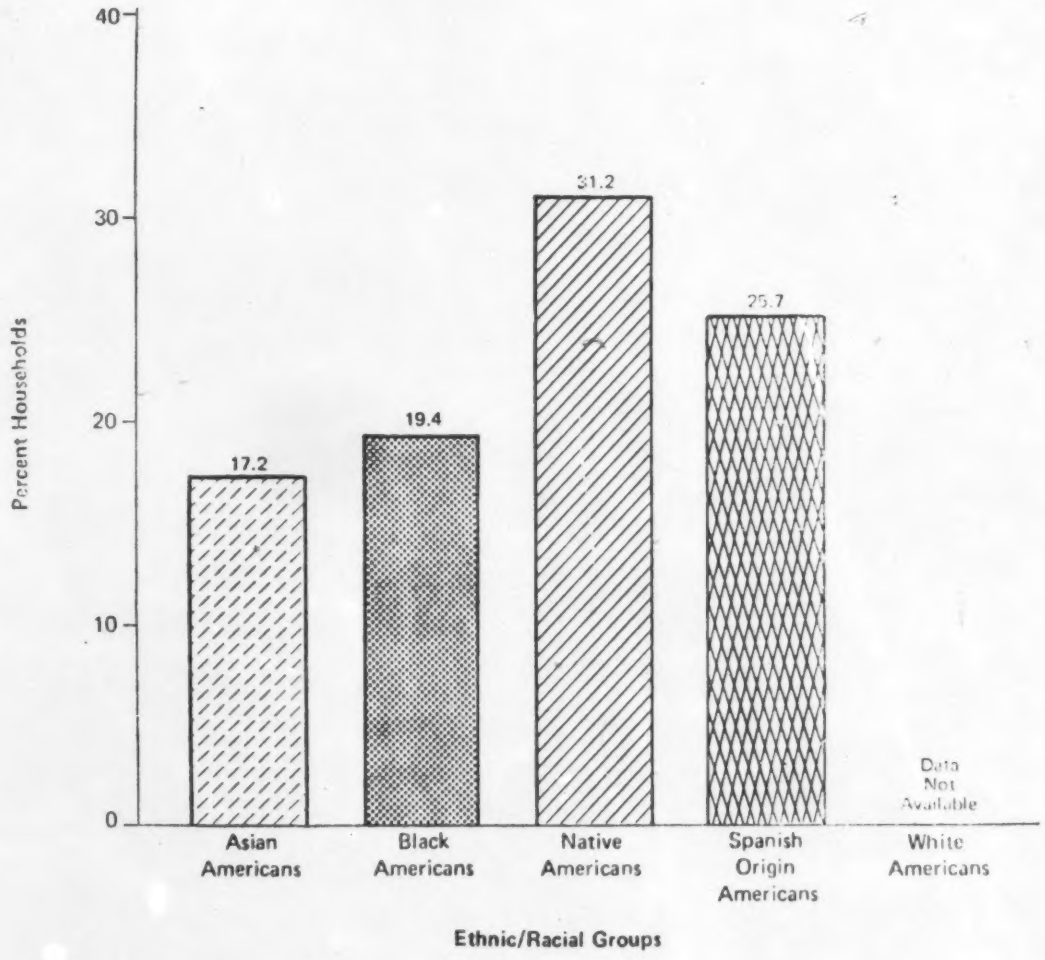
CHART 8

PERCENT OF HOUSEHOLDS WITH MORE THAN
ONE PERSON PER ROOM BY ETHNIC/RACIAL GROUP, 1970



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